MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02738

Item 13: 6218 7/1/57 02732

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 4yrs.1mo.10days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Frederick
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Emmitsburg 10 x 22
d. STREET ADDRESS: P.O. Box 267
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Harriett; Middle White; Last ANNAN

4. DATE OF DEATH: Month March; Day 24; Year 1957

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: August 23, 1865

9. AGE (In years last birthday): 91 yrs.

IF UNDER 1 YEAR: Months; Days. IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife

10b. KIND OF BUSINESS OR INDUSTRY: -

11. BIRTHPLACE (State or foreign country): Pennsylvania

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: ~~Unknown~~ William R. ~~Annan~~ White

14. MOTHER'S MAIDEN NAME: ~~Unknown~~ Annie Horner

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): -

16. SOCIAL SECURITY NO.: 219-20-0902

17. INFORMANT: Address: Springfield Hospital records.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Arteriosclerotic heart disease — INTERVAL BETWEEN ONSET AND DEATH: Years

420.0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b):

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): C.B.S. assoc. with changes of growth, metabolism, or nutrition, senile brain disease with psychotic reaction.

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Month, Day, Year; Hour a. m. p. m.; 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from February 14, 1953, to March 24, 1957, that I last saw the deceased alive on March 24, 1957, and that death occurred at 9:00 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Walther H. Sonnenfeldt, M.D. — ADDRESS (Street, city or town, state): Springfield State Hospital — DATE SIGNED: 3/25/57

PHYSICIAN'S NAME (Type): Walther H. Sonnenfeldt, M.D. — Sykesville, Maryland.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 3/27/1957

22c. NAME OF CEMETERY OR CREMATORY: Evergreen Cemetery

22d. LOCATION (City, town, or county) (State): Gettysburg, Pa

23. FUNERAL DIRECTOR'S SIGNATURE: L. L. Allison — ADDRESS: Emmitsburg, Md.

24a. REC'D BY REGISTRAR DATE: MAR 27 19

24b. REGISTRAR'S SIGNATURE: C. Harry Hess

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be signed for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02733

CERTIFICATE OF DEATH

02739

Reg. Dist. No. 26

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Patapsco
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Patapsco Rd

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland — b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): x2 Patapsco
d. STREET ADDRESS: Patapsco Rd
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Beulah — Middle: Jessie — Last: ARbaugh
4. DATE OF DEATH: Month: March — Day: 2 — Year: 19 57

5. SEX: Female
6. COLOR OR RACE: white
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: October 16, 1896
9. AGE (In years last birthday): 60 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George Wesley Pickett
14. MOTHER'S MAIDEN NAME: Sarah Elizabeth Leppo

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: —
17. INFORMANT — Address: George William Pickett - Patapsco Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Metastatic Carcinoma Lung. — INTERVAL BETWEEN ONSET AND DEATH: July 1956
DUE TO
(b): Primary Carcinoma Left Breast — Aug 1953
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
170X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July 4th, 1956 to March 3, 1957 that I last saw the deceased alive on February 27, 1957 and that death occurred at 2:15 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Joseph E Bush M.D. — ADDRESS (Street, city or town, state): Hampstead Md — DATE SIGNED: 3/5/57

PHYSICIAN'S NAME (Type): Joseph E. Bush MD — Hampstead Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3-5-57
22c. NAME OF CEMETERY OR CREMATORY: Carrollton Church of God
22d. LOCATION (City, town, or county) (State): Carrollton, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: John R. Byers Westminster, Md.
24a. REC'D BY REGISTRAR — DATE: 3-4-57
24b. REGISTRAR'S SIGNATURE: Harriet Mills

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02740

02733

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 2½ days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Balto. City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 3 V 01-4
d. STREET ADDRESS: 2801 List Ave., Balto. 14.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First George — Middle — Last AUER

4. DATE OF DEATH: Month March — Day 29 — Year 1957

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Aug. 21, ~~1870~~ 1872
9. AGE (In years last birthday): 84 ~~86~~ yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Sexton Retired
10b. KIND OF BUSINESS OR INDUSTRY: Unk
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George Auer
14. MOTHER'S MAIDEN NAME: Elizabeth -

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): -
16. SOCIAL SECURITY NO.: 218-12-3343
17. INFORMANT — Address: Springfield Hospital Records.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic heart disease — INTERVAL BETWEEN ONSET AND DEATH: Years
420.0
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b):
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): C.B.S. associated with arteriosclerosis with psychotic reaction.
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from March 27, 1957, to March 29, 1957, that I last saw the deceased alive on March 28, 1957, and that death occurred at 7:00 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Edmund B. Lusthaus M.D.
ADDRESS (Street, city or town, state): Springfield State Hospital
DATE SIGNED: 3/29/57

PHYSICIAN'S NAME (Type): Edmund B. Lusthaus, M.D. — Sykesville, Maryland.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 4/1/1957
22c. NAME OF CEMETERY OR CREMATORY: Holy Cross Cemetery
22d. LOCATION (City, town, or county) (State): A.A.Co. Maryland

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Leonard J. Ruck 5305 Harford Road #14
24a. REC'D BY REGISTRAR DATE: 3-29-57
24b. REGISTRAR'S SIGNATURE: C. Harry Weir

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the [illegible] director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH--BALTIMORE, 18

02735

CERTIFICATE OF DEATH

02741

Reg. Dist. No. 7H

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Sykesville, Maryland
c. LENGTH OF STAY IN 1b: 6 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Frederick
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Frederick, Maryland 10112
d. STREET ADDRESS: 480 W. South Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

15

3. NAME OF DECEASED (Type or print): First: Mary (Also known as Mary E. Barthlow) Middle: Catherine Elizabeth Last: Poole Barthlow

4. DATE OF DEATH: Month: 3 Day: 18 Year: 1957

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
8. DATE OF BIRTH: 7-5-1915
9. AGE (In years last birthday): 41 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

1

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Presser
10b. KIND OF BUSINESS OR INDUSTRY: Clothing Firm
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Ernest Poole
14. MOTHER'S MAIDEN NAME: Goldie Williams

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: Unk
17. INFORMANT: Hospital records — Address

I

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Rheumatic heart disease, active — INTERVAL BETWEEN ONSET AND DEATH: unknown
401.3
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

2

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Psychotic depressive reaction
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. / Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 3-12, 1957, to 3-18, 1957, that I last saw the deceased alive on 3-18, 1957, and that death occurred at 4:25 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Edmund Lusthaus M.D.
ADDRESS (Street, city or town, state): Springfield State Hospital, Sykesville, Maryland
DATE SIGNED: 3-18-1957

1

PHYSICIAN'S NAME (Type): Edmund Lusthaus, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 21 March 1957
22c. NAME OF CEMETERY OR CREMATORY: Mount Olivet Cemetery
22d. LOCATION (City, town, or county) (State): Frederick, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: M. R. Etchison & Son, Frederick, Maryland
24a. REC'D BY REGISTRAR DATE: 3-20-57
24b. REGISTRAR'S SIGNATURE: C. Harry Weer

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02736 Item 2 FilmG212 3-22-57 et

02742

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: since 2-15-57
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Baltimore City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 2, 3 Vol-4
d. STREET ADDRESS: 30 East Lanvale Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Phillip; Middle: ; Last: Bernard

4. DATE OF DEATH: Month: 3; Day: 9; Year: 1957

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 9-9-74

9. AGE (In years last birthday): 82 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): actor

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): So.Carolina

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Phillip Bernard

14. MOTHER'S MAIDEN NAME: Mary Baker

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): unkn
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 220-05-3105 unkn ov

17. INFORMANT: Hospital Records
Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: hours
331X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Hypertension — years
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): C.B.S. assoc. with cerebral arteriosclerosis with psych. reaction

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m.; Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 2-15- 19 57 to 3- 9- 57 19, that I last saw the deceased alive on March 9, 1957, and that death occurred at 6 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Edmund Isthams M.D.
ADDRESS (Street, city or town, state): Springfield State Hospital
DATE SIGNED: 3-10-57

PHYSICIAN'S NAME (Type): Edmund Isthams
Sykesville, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify)

22b. DATE THEREOF: Mar. 13/57

22c. NAME OF CEMETERY OR CREMATORY: Cathedral

22d. LOCATION (City, town, or county) (State): Baltimore Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Rita Wiedefeld
ADDRESS: 200 E. Biddle St.

24a. REC'D BY REGISTRAR DATE: MAR 1 3 1957

24b. REGISTRAR'S SIGNATURE: C. Harry Fears

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the [illegible] director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02737

CERTIFICATE OF DEATH

02743

Reg. Dist. No. 76

1. PLACE OF DEATH
a. COUNTY CARROLL MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FINKSBURG
c. LENGTH OF STAY IN 1b 20YRS.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND b. COUNTY CARROLL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FINKSBURG RD#1
d. STREET ADDRESS 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First HOWARD Middle EDWARD Last BONNER

4. DATE OF DEATH Month MARCH Day 8 Year 1957

5. SEX MALE

6. COLOR OR RACE WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH DEC. 8, 1909

9. AGE (In years last birthday) 47 yrs

IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ACCOUNTANT

10b. KIND OF BUSINESS OR INDUSTRY CONGOLEUM-NAIRN

11. BIRTHPLACE (State or foreign country) GAMBER CARROLL Co. Md. U.S.A.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME HENRY EDWARD BONNER

14. MOTHER'S MAIDEN NAME AMELIA MILLER

15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no or unknown) — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT Address MRS. H.E. BONNER, FINKSBURG, Md. RD#1

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Brain Tumor (Malignant) — INTERVAL BETWEEN ONSET AND DEATH 15 mo

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from April, 1956, to 3-8, 1957, that I last saw the deceased alive on 3-7, 1957, and that death occurred at 12:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE M.C. Porterfield M.D. ADDRESS (Street, city or town, state) Hampstead Md DATE SIGNED 3/8/57

PHYSICIAN'S NAME (Type) M.C. Porterfield M.D. Hampstead, Md. 3/8/57

22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL

22b. DATE THEREOF 3/10/57

22c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery

22d. LOCATION (City, town, or county) (State) GAMBER CARROLL Co. Md.

23. FUNERAL DIRECTOR'S SIGNATURE J.E. Myers, Jr. ADDRESS Westminster, Md.

24a. REC'D BY REGISTRAR DATE 3-8-57

24b. REGISTRAR'S SIGNATURE Harold Miller

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be delivered with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02744

02738

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: Since 1-20-55

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: City ✓
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore (24)
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital
d. STREET ADDRESS: 1101 Pinney Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: William — Middle: Baker — Last: BORKOWICZ

4. DATE OF DEATH: Month: March — Day: 5 — Year: 1957

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 2-5-86

9. AGE (In years last birthday): 71 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min

10a. USUAL OCCUPAT ON (Give kind of work done during most of working life, even if retired): Toolroom Worker

10b KIND OF BUSINESS OR INDUSTRY:

11 BIRTHPLACE (State or foreign country): Maryland

12 CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Joseph Borkowicz

14. MOTHER'S MAIDEN NAME: Constance Antkowiak

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 215-07-1235

17. INFORMANT: Address: Records - Springfield State Hospital

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Bronchopneumonia - Hypostatic — INTERVAL BETWEEN ONSET AND DEATH: 3 days

F 71X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Chronic brain syndrome associated with circulatory disturbance with cerebral arteriosclerosis, with psychotic reaction.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACC DENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from January 20, 1955, to 3-5, 1957, that I last saw the deceased alive on March 5, 1957, and that death occurred at 11 A. M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Walther H Sonnenfeldt M.D. ADDRESS (Street, city or town, state): Springfield State Hospital DATE SIGNED: 3/5/57

PHYSICIAN'S NAME (Type): Walther H. Sonnenfeldt, M. D. Sykesville, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): 3-9-57
22b. DATE THEREOF: Burial
22c. NAME OF CEMETERY OR CREMATORY: ST. STANISLAUS
22d. LOCATION (City, town, or county) (State): 1300 DUNDALK AVE

23. FUNERAL DIRECTOR'S SIGNATURE: George A. Weber ADDRESS: 705 S. Conn st

24a. REC'D BY REGISTRAR DATE: 3/6/57

24b. REGISTRAR'S SIGNATURE: C. Harry Heers

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02739

CERTIFICATE OF DEATH

02745

Reg. Dist. No. 87

1. PLACE OF DEATH
a. COUNTY: CARROLL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): UNION BRIDGE
c. LENGTH OF STAY IN 1b: YEARS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: RURAL

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: MARYLAND — b. COUNTY: CARROLL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X UNION BRIDGE
d. STREET ADDRESS: RURAL
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First LAURA — Middle PRICE — Last BOSTIAN

4. DATE OF DEATH: Month MARCH — Day 12 — Year 1957

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: MAY 24-1875

9. AGE (In years last birthday): 81 yrs

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEKEEPER

10b. KIND OF BUSINESS OR INDUSTRY: AT HOME

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: JACOB PRICE

14. MOTHER'S MAIDEN NAME: ALICE KELLY

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT: C.C. BOSTIAN — Address: UNION BRIDGE R.D. MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 4 days

DUE TO (b): Arterial Sclerosis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Mar 12. 1957 to Mar 12. 1957 that I last saw the deceased alive on Mar 10 1957, and that death occurred at 2:25 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: J. H. Messler M.D. — ADDRESS (Street, city or town, state): Union Bridge md. — DATE SIGNED: Mar. 12 1957

PHYSICIAN'S NAME (Type): J. H. MESSLER M.D

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 3/14/57

22c. NAME OF CEMETERY OR CREMATORY: LUTHERAN CEM.

22d. LOCATION (City, town, or county) (State): UNIONTOWN, MD.

23. FUNERAL DIRECTOR'S SIGNATURE: C.O. Hartley Sons — ADDRESS: Union Bridge, Md

24a. REC'D BY REGISTRAR/DATE: 3-14-57

24b. REGISTRAR'S SIGNATURE: Luke L. Fiels

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02740

CERTIFICATE OF DEATH

02746

Reg. Dist. No. 74

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)
ISM 9/55

1. PLACE OF DEATH a. COUNTY: Carroll	MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland	b. COUNTY: Allegany
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville	c. LENGTH OF STAY IN 1b: 3mo. 11 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital		d. STREET ADDRESS	e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
Ralph	Drew	BROADRUP	March	17	1957

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White		6-13-91	65 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Banker	Banking	Maryland	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
George L. Broadrup	Emma Wachter

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT Address
Yes	1st W. War	Unk	Springfield State Hospital - Sykesville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Edema of Lungs	5 hours
450.0 DUE TO		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)	Congestive Heart Failure	5 hours
DUE TO (c)	Generalized Arteriosclerosis	Years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)	Huntington's Chorea, with psychotic reaction.	19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, Farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)

21. I certify that I attended the deceased from 12-6, 1956, to 3-17, 1957, that I last saw the deceased alive on 3-17, 1957, and that death occurred at 2:01 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Martin Gross M.D. ADDRESS (Street, city or town, state): Springfield State Hospital DATE SIGNED: 3-18-57

PHYSICIAN'S NAME (Type): Martin Gross, M. D. Sykesville, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	3-20-57	Rose Hill	Cumberland, Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
A. Lee Libby - Cumberland, Md	3-18-57	C. Haney Weir

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02741

CERTIFICATE OF DEATH

02747/74

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 5yrs. 2mo 8all days
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Springfield State Hospital.

2. USUAL RESIDENCE (Where deceased lived. If institution- Residence before admission)
a. STATE: Maryland — b. COUNTY: Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rising Sun
d. STREET ADDRESS: Unknown
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Emma — Middle: Stephens — Last: Brown

4. DATE OF DEATH: Month: March — Day: 30 — Year: 1957

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: 7-22- 1890

9. AGE (In years last birthday): 66 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unknown

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Clifford N Brown

14. MOTHER'S MAIDEN NAME: Mary Stephens

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT — Address: Hospital Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Arteriosclerotic heart disease. — INTERVAL BETWEEN ONSET AND DEATH: years

4420

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Generalized arteriosclerosis — years

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Psychosis with convulsives disorder, epileptic deterioration. Bronchopneumonia. days

19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work [ ] Not while at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1-19-51, 1951, to 3-30-, 1957, that I last saw the deceased alive on 3-30-57, 1957, and that death occurred at 7P.M. M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Agustin del Campo M.D. — ADDRESS (Street, city or town, state): Springfield State Hospital — DATE SIGNED: 3-31-57

PHYSICIAN'S NAME (Type): Agustin del Campo.M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 4-1-1957

22c. NAME OF CEMETERY OR CREMATORY: Roseneath

22d. LOCATION (City, town, or county) (State): Catonsville Md

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Joseph R Grant North East Md

24a. REC'D BY REGISTRAR DATE: APR 2 1957

24b. REGISTRAR'S SIGNATURE: C. Harry Heer

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02742

CERTIFICATE OF DEATH

Reg. Dist. No. 02748

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: City

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville

c. LENGTH OF STAY IN 1b: 2yrs.2mos.6days

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

d. STREET ADDRESS: 2820 Fox Street

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Thomas Middle: Kent Last: BROWN

4. DATE OF DEATH: Month: March Day: 5 Year: 1957

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: April 9, 1874

9. AGE (In years last birthday): 82 yrs.

IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Stonecutter

10b. KIND OF BUSINESS OR INDUSTRY: -

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Enoch Brown

14. MOTHER'S MAIDEN NAME: Martha Bell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service): -

16. SOCIAL SECURITY NO.: -

17. INFORMANT Address: Springfield Hospital Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY- IMMEDIATE CAUSE (a): Bronchopneumonia, unresolved — INTERVAL BETWEEN ONSET AND DEATH: 24 hrs.

491.0

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) Gastro-intestinal hemorrhage — 8 days

DUE TO

(c) Peptic ulcer — Unknown

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): C.B.S. associated with circ. disturbance with cerebral arteriosclerosis with psychotic reaction.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from December 29, 1954, to March 5, 1957, that I last saw the deceased alive on March 5, 1957, and that death occurred at 10:45 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Walther H. Sonnenfeldt M.D. ADDRESS (Street, city or town, state): Springfield Hospital DATE SIGNED: 3/5/57

PHYSICIAN'S NAME (Type): Walther H. Sonnenfeldt, M.D. Sykesville, Maryland.

22a. ~~BURIAL, CREMATION, REMOVAL (Specify)~~: Embalmed

22b. DATE THEREOF: 3-6-57

22c. ~~NAME OF CEMETERY OR CREMATORY~~: U.B.W. Crematory Board

22d. LOCATION (City, town, or county) (State): Baltimore, Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Frank A. Newell Pikesville, Md.

24a. REC'D BY REGISTRAR DATE: 3/7/57

24b. REGISTRAR'S SIGNATURE: C. Perry Rees

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02749

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02743

Reg. Dist. No. 50

1. PLACE OF DEATH
a. COUNTY: CARROLL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): NEW WINDSOR
c. LENGTH OF STAY IN 1b: 24 hrs -
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): BRETHERN SERVICE CENTER

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE — b. COUNTY —
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): FRANKFURT GERMANY
d. STREET ADDRESS: ROEDELHEIMER LANDSTR 36
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First SYBILLE Middle — Last BRUECK

4. DATE OF DEATH: Month MAR Day 18 Year 1957

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: DEC 13 1932
9. AGE (In years last birthday): 24 yrs.
IF UNDER 1 YEAR: Months — Days —
IF UNDER 24 HRS.: Hours — Min. —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student
10b. KIND OF BUSINESS OR INDUSTRY: COLLEGE
11. BIRTHPLACE (State or foreign country): GERMANY
12. CITIZEN OF WHAT COUNTRY? GERMANY

13. FATHER'S NAME: WALTER BRUECK
14. MOTHER'S MAIDEN NAME: UNKNOWN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO: NONE
17. INFORMANT: Address: Brethern Service Commission Frederick New Windsor

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): SUFFOCATION - by hanging - — INTERVAL BETWEEN ONSET AND DEATH: minutes
974X
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II. of item 18.): Hanged by neck -
20c. TIME OF INJURY Hour o. m. p m 3 - Month, Day, Year 18 1957
20d. INJURY OCCURRED While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) New Windsor (County) Carroll (State) Md

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: James T. Marsh M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 3/18/57

EXAMINER'S NAME (Type): JAMES T MARSH

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 3/23/57
22c. NAME OF CEMETERY OR CREMATORY: MEISSEN
22d. LOCATION (City, town, or county) (State): MEISSEN GERMANY

23. FUNERAL DIRECTOR'S SIGNATURE: D C Hartzler & Sons, New Windsor, Md. ADDRESS
24a. REC'D BY REGISTRAR DATE: MAR 21 1957
24b. REGISTRAR'S SIGNATURE: Lucie Benedict

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the [illegible] Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02750

02741 **CERTIFICATE OF DEATH**

Reg. Dist. No. 7H

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 15yrs.6mos.5days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Lonaconing
d. STREET ADDRESS: -
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Bessie; Middle: ; Last: BUCKLE

4. DATE OF DEATH: Month: March; Day: 1; Year: 1957

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: June 14, 1880

9. AGE (In years last birthday): 76 yrs.

IF UNDER 1 YEAR: Months: ; Days: — IF UNDER 24 HRS.: Hours: ; Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Othe Waxler

14. MOTHER'S MAIDEN NAME: Levina Green

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: Unk

17. INFORMANT: Springfield Hospital Records. Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Chronic mitral valvular heart disease — INTERVAL BETWEEN ONSET AND DEATH: Years

DUE TO

410X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) Aspiration bronchopneumonia with abscess formation — Week.

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Psychosis with Cerebral arteriosclerosis.

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED White at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July 1, 1950 to March 1, 1957, that I last saw the deceased alive on February 28, 1957, and that death occurred at 4:50 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Walther H. Sonnenfeldt M.D. ADDRESS (Street, city or town, state): Springfield State Hospital DATE SIGNED: 3/1/57

PHYSICIAN'S NAME (Type): Walther H. Sonnenfeldt, M.D. Sykesville, Maryland.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 3-4-57

22c. NAME OF CEMETERY OR ~~CREMATORY~~: Lonaconing

22d. LOCATION (City, town, or county) (State): Lonaconing, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: M. Eichorn ADDRESS: Lonaconing, Md.

24a. REC'D BY REGISTRAR DATE: 3-1-57

24b. REGISTRAR'S SIGNATURE: C. Harry Lee

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be delivered with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02751

02723 **CERTIFICATE OF DEATH**

Reg. Dist. No. 26

1. PLACE OF DEATH
a. COUNTY: CARROLL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WESTMINSTER
c. LENGTH OF STAY IN 1b: 50 YRS.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 204 PENNA. AVE.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: CARROLL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WESTMINSTER
d. STREET ADDRESS: 204 PENNA. AVE.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First IRENE Middle ELIZABETH Last CHREST

4. DATE OF DEATH: Month MARCH Day 7 Year 1957

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: SEPT. 7, 1875
9. AGE (In years last birthday): 81 yrs.
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS: Hours ___ Min ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House-wife
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): CARROLL CO MD.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: CHRISTIAN A. GUNTHER
14. MOTHER'S MAIDEN NAME: ANNIE GIGGARD

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): —
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: —
17. INFORMANT: MISS LILLIAN L. CHREST, Address 204 PENNA. AVE WESTMINSTER Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebral arterial thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 4 Hrs + 6 Hrs
421.4
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) ___
DUE TO
(c) Vascular heart disease — 14 yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June, 1950 to Mar 7, 1957, that I last saw the deceased alive on Mar 6, 1957, and that death occurred at 3:05 P.M., from the causes and on the date stated above.
ACTUAL SIGNATURE: E Reese Wilkens M.D. ADDRESS (Street, city or town, state): 15 Kemper Ave. DATE SIGNED: 3/7/57
PHYSICIAN'S NAME (Type): E. Reese WILKENS, Westminster Md

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 3/9/57
22c. NAME OF CEMETERY ~~OR CREMATORY~~: LEISTER'S CEMETERY
22d. LOCATION (City, town, or county) (State): RURAL, WESTMINSTER, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: J. E. Myers Jr. ADDRESS: Westminster, Md.
24a. REC'D BY REGISTRAR DATE: 3-8-57
24b. REGISTRAR'S SIGNATURE: Hannah Mills

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02752

02745 CERTIFICATE OF DEATH

Reg. Dist. No. C

1. PLACE OF DEATH
a. COUNTY CARROLL — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural WESTMINSTER
c. LENGTH OF STAY IN 1b 1 MO.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.D. 5

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE V.A. — b. COUNTY
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First SAMUEL Middle MILTON Last CLEGG
4. DATE OF DEATH Month MARCH Day 1 Year 1957

5 SEX M
6 COLOR OR RACE W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH JAN. 25, 1870
9 AGE (In years last birthday) 87 yrs
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RET. FARMER
10b. KIND OF BUSINESS OR INDUSTRY
11 BIRTHPLACE (State or foreign country) V.A.
12 CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME DANIEL CLEGG
14 MOTHER'S MAIDEN NAME ELLEN THORPE

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO (If yes, give war or dates of service)
16 SOCIAL SECURITY NO. NONE
17. INFORMANT ADA V. CLEGG (wife) Address R.D. 5 WESTMINSTER, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial degeneration — INTERVAL BETWEEN ONSET AND DEATH 2 weeks
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from Feb 1, 1957 to Mar 1, 1957, that I last saw the deceased alive on Feb 16, 1957, and that death occurred at 2 P.M., from the causes and on the date stated above.
ACTUAL SIGNATURE [illegible] M.D. ADDRESS (Street, city or town, state) [illegible] DATE SIGNED 3/2/57
PHYSICIAN'S NAME (Type) E. REESE [illegible] M.D. [illegible]

22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
22b. DATE THEREOF 3-3-1957
22c. NAME OF CEMETERY OR CREMATORY ZION METHODIST CEM.
22d LOCATION (City, town, or county) (State) RD 6 WESTMINSTER MD.

23. FUNERAL DIRECTOR'S SIGNATURE David C. Bankard ADDRESS Westminster, Md.
24a. REC'D BY REGISTRAR DATE 3-4-57
24b. REGISTRAR'S SIGNATURE [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AT5 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02746

CERTIFICATE OF DEATH

02753

Reg. Dist. No. 74

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 24 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Balto. City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 3[illegible] 4
d. STREET ADDRESS: 3523 Brehms Lane.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Bernard; Middle: Vincent; Last: COLLINS

4. DATE OF DEATH: Month: March; Day: 7; Year: 1957

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: March 28, 1894

9. AGE (In years last birthday): 62 yrs
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk

10b. KIND OF BUSINESS OR INDUSTRY: Grain Elevator

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: William Collins

14. MOTHER'S MAIDEN NAME: Sarah Philbin

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): ~~World War I~~ (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 213-14-4487

17. INFORMANT: Springfield Hospital Records — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic heart disease — INTERVAL BETWEEN ONSET AND DEATH: Years
420.0
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): C.B.S. associated with arteriosclerosis.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m.; Month; Day; Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from February 13, 1957, to March 7, 1957, that I last saw the deceased alive on March 6, 1957, and that death occurred at 1:00A M, from the causes and on the date stated above

ACTUAL SIGNATURE: Walther H. Sonnenfeldt M.D. — ADDRESS (Street, city or town, state): Springfield State Hospital — DATE SIGNED: 3/7/57

PHYSICIAN'S NAME (Type): Walther H. Sonnenfeldt, M.D. — Sykesville, Maryland.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 3-11-1957

22c. NAME OF CEMETERY OR CREMATORY: New Cathedral Cemetery

22d. LOCATION (City, town, or county) (State): Edmondson Ave. Balto: Md.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: George J. Ruth, Inc. - 1735 Harford Avenue, Balto: Md.

24a. REC'D BY REGISTRAR — DATE: MAR 11 1957

24b. REGISTRAR'S SIGNATURE: B. Henry Heers

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02747

CERTIFICATE OF DEATH

02754 74
Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH a. COUNTY: Carroll — MARYLAND	2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE: Maryland b. COUNTY: Frederick
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville	c. LENGTH OF STAY IN 1b: 3yrs.5mos.3days
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Frederick	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital	d. STREET ADDRESS: 13 N. Jefferson St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒	
3. NAME OF DECEASED (Type or print): First Margie Middle Alice Last Albaugh DORSEY	4. DATE OF DEATH: Month March Day 6, Year 1957
5 SEX: Female	6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8. DATE OF BIRTH: January 18, 1880
9. AGE (In years last birthday): 77 yrs.	IF UNDER 1 YEAR: Months Days — IF UNDER 24 HRS: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife	10b. KIND OF BUSINESS OR INDUSTRY: -
11 BIRTHPLACE (State or foreign country): Maryland	12 CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: George W. Albaugh	14 MOTHER'S MAIDEN NAME: Sara Jane Valentine
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): -	16 SOCIAL SECURITY NO: -
17 INFORMANT Address: Springfield Hospital Records.	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Pulmonary tuberculosis — INTERVAL BETWEEN ONSET AND DEATH: unknown

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): C.B.S. associated with circ. disturbance, with cerebral arteriosclerosis, with psychotic reaction.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from October 3, 1953, to March 6, 1957, that I last saw the deceased alive on March 6, 1957, and that death occurred at 10:15 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Walther H Sonnenfeldt M.D. — ADDRESS (Street, city or town, state): Springfield State Hospital — DATE SIGNED: 3/7/57

PHYSICIAN'S NAME (Type): Walther H. Sonnenfeldt, M.D. — Sykesville, Maryland.

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF: Mar. 9. 1957	22c. NAME OF CEMETERY OR CREMATORY: Mt. Tabor Cemetery	22d. LOCATION (City, town, or county) (State): Rocky Ridge Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE: H E Mailey	ADDRESS: Frederick Md.	24a. REC'D BY REGISTRAR DATE: 7 March 1957	24b. REGISTRAR'S SIGNATURE: C. Darry Hess	

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02748 **CERTIFICATE OF DEATH** Reg. Dist. No. 02755 75

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Manchester
c. LENGTH OF STAY IN 1b: 5 Yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Long View Nursing Home

2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 3908 N. Charles St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First Louise — Middle B. — Last Duvall

4. DATE OF DEATH: Month March — Day 28, — Year 1957

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Not obtainable
9. AGE (In years last birthday): About 89 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY: ———
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: John B. N. Berry
14. MOTHER'S MAIDEN NAME: Rosalie Eugenia Berry

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT Address: Mrs. Sidney S. Zell 3908 N. Charles St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 3 4 months
DUE TO
(b): Coronary arterio-sclerosis & Angina — 15 years
DUE TO
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m., 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July 5, 1951 to March 28, 1957, that I last saw the deceased alive on 3-27, 1957, and that death occurred at 3a M, from the causes and on the date stated above.

ACTUAL SIGNATURE: M. C. Porterfield M.D. ADDRESS (Street, city or town, state): Hampstead, Md. DATE SIGNED: 3/28/57

PHYSICIAN'S NAME (Type): M. C. Porterfield, M.D. Hampstead, Md. 3/28/57

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3/29/57
22c. NAME OF CEMETERY OR CREMATORY: Green Mount
22d. LOCATION (City, town, or county) (State): Baltimore, Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: H. W. Meeks and Son 805 N. Calvert St. Balto
24a. REC'D BY REGISTRAR DATE: 3-29-57
24b. REGISTRAR'S SIGNATURE: Mrs. H. K. Denney

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02756

02749 **CERTIFICATE OF DEATH**

Reg. Dist. No. 74

1 PLACE OF DEATH
a. COUNTY CARROLL MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SYKESVILLE
c. LENGTH OF STAY IN 1b 29 yr
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRINGFIELD STATE HOSP

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MD
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE
d. STREET ADDRESS 15 W HAMBURG STR.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First LULA Middle EATON Last
4. DATE OF DEATH Month 3 Day 13 Year 1957

5 SEX F
6. COLOR OR RACE W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH 10-22-1894
9 AGE (In years last birthday) 62 yrs
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) BALTIMORE, Md.
12 CITIZEN OF WHAT COUNTRY? U. S. A

13. FATHER'S NAME ECKHARDT SMITH
14. MOTHER'S MAIDEN NAME MARGARET BECKER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Address SPRINGFIELD STATE HOSP.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE — INTERVAL BETWEEN ONSET AND DEATH: weeks

DUE TO (b) Hypertensive Cardiovascular — years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) Delusional Arteriosclerosis — years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Schizophrenia, paranoid type

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 2-22-28, 19____, to 3-13, 1957, that I last saw the deceased alive on 3-13, 1957, and that death occurred at 7 15 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE Gertrud Sonnenfeld M.D. ADDRESS (Street, city or town, state) Springfield State Hospital Sykesville Md. DATE SIGNED 3/13/57

PHYSICIAN'S NAME (Type) Gertrud Sonnenfeld Springfield State Hospital Sykesville Md.

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 3/18/57
22c. NAME OF CEMETERY OR CREMATORY Western Cem.
22d. LOCATION (City, town, or county) (State) Balto., Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Wm. J. Tietjen & Sons - Balto 17 Md
24a. REC'D BY REGISTRAR DATE 3/15/57
24b. REGISTRAR'S SIGNATURE C. Harry Hess

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02757

02750

CERTIFICATE OF DEATH

Reg. Dist. No. 77

1. PLACE OF DEATH
a. COUNTY Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hampstead
c. LENGTH OF STAY IN 1b 75 yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION ✓

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE Maryland b. COUNTY Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hampstead
d. STREET ADDRESS ✓
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print) First MARY Middle A-M- Last ELSEROAD

4. DATE OF DEATH Month March Day 5 Year 1957

5. SEX F

6. COLOR OR RACE W

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH Oct 26-1877

9. AGE (In years last birthday) 79 yrs.

IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework

10b. KIND OF BUSINESS OR INDUSTRY own home

11. BIRTHPLACE (State or foreign country) Maryland

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME Columbus Elsroad

14. MOTHER'S MAIDEN NAME Ellen Annadorit

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No

16. SOCIAL SECURITY NO 700

17. INFORMANT Address Walter Elsroad, Upperco Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH 4 hrs

430.1

DUE TO (b) Hypertension Arterio-Vascular Lesion

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year

20d. INJURY OCCURRED Whilе at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July 4, 1954 to March 5, 1957 that I last saw the deceased alive on March 5, 1957, and that death occurred at 4:50 M, from the causes and on the date stated above.

ACTUAL SIGNATURE Joseph E. Bush M.D. ADDRESS (Street, city or town, state) Hampstead, Md DATE SIGNED 3/6/57

PHYSICIAN'S NAME (Type) Joseph E. Bush MD Hampstead, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial

22b. DATE THEREOF Mar 8/57

22c. NAME OF CEMETERY OR CREMATORY Wesley

22d. LOCATION (City, town, or county) (State) Carroll Co Md

23. FUNERAL DIRECTOR'S SIGNATURE Edw A Ripton ADDRESS Hampstead Md

24a. RECD BY REGISTRAR DATE 3-6-57

24b. REGISTRAR'S SIGNATURE Spencer Ellis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the [illegible] director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02751 02758

CERTIFICATE OF DEATH

Reg. Dist. No. 18

1 PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): rural-Westminster
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Winfield

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): x2 Winfield
d. STREET ADDRESS: Rural-Westminster
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First JOSEPH Middle A. Last EYLER

4. DATE OF DEATH: Month March Day 19 Year 1957

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH: 7-31-1886
9 AGE (In years last birthday): 70 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter
10b. KIND OF BUSINESS OR INDUSTRY: General
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Joseph A. Eyler
14. MOTHER'S MAIDEN NAME: Deborah Spurrier

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 219-07-2057
17. INFORMANT: Mrs. Anna Eyler, Same — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Oedema of lungs — INTERVAL BETWEEN ONSET AND DEATH: 3 4 hours

DUE TO (b): Chronic Myocarditis — about 3 yrs

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

4 d. 2h

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): none

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from March 1st, 1953, to A 3-18, 1957, that I last saw the deceased alive on 3-18, 1957, and that death occurred at 12:45 M. from the causes and on the date stated above.

ACTUAL SIGNATURE: C L Billingslea M.D. — ADDRESS (Street, city or town, state): Westminster Md. — DATE SIGNED: 3-19-57

PHYSICIAN'S NAME (Type): C. L. BILLINGSLEA — Westminster, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 3-21-1957
22c. NAME OF CEMETERY OR CREMATORY: Ebenezer
22d. LOCATION (City, town, or county) (State): Carroll Co., Maryland

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: C. M. Waltz, Winfield, Maryland
24a. REC'D BY REGISTRAR DATE: 3 21 1957
24b. REGISTRAR'S SIGNATURE: Mary Fraser

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

02752 02759

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 81

1. PLACE OF DEATH
a. COUNTY: CARROLL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): KEYMAR RURAL
c. LENGTH OF STAY IN 1b: YEARS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): NEAR DETOUR

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: CARROLL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): KEYMAR RURAL
d. STREET ADDRESS: NEAR DETOUR
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First JOHN Middle CARLTON Last FLEMING

4. DATE OF DEATH: Month MARCH Day 14 Year 1957

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: MAY 15-1949

9. AGE (In years last birthday): 7 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): STUDENT

10b. KIND OF BUSINESS OR INDUSTRY: 2ND. GRADE

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: CARLTON D. FLEMING

14. MOTHER'S MAIDEN NAME: JUNE BRUNER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No — (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT: C.D. FLEMING, Address: KEYMAR RURAL MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): DISLOCATED CERVICAL VERTEBRA — INTERVAL BETWEEN ONSET AND DEATH: SUDDEN

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Tree fell on him

20c. TIME OF INJURY: Hour 3 p.m. — Month, Day, Year: 3/14 1957

20d. INJURY OCCURRED: While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home farm

20f. (City or town): Detour (County): Carroll (State): Md

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: James T. Marsh M.D

EXAMINER'S NAME (Type): JAMES T MARSH

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: 3/14/57

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 3/17/57

22c. NAME OF CEMETERY OR CREMATORY: MT UNION CEM.

22d. LOCATION (City, town, or county) (State): UNION BRIDGE RURAL MD.

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: D.D. Hartsler & Sons, Union Bridge, Md

24a. REC'D BY REGISTRAR DATE: MAR 18 1957

24b. REGISTRAR'S SIGNATURE: Leslie L. Repp

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02760

02753 **CERTIFICATE OF DEATH**

Reg. Dist. No. 76

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md — b. COUNTY: Carroll

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pleasant Valley

c. LENGTH OF STAY IN 1b: 80 yrs

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Pleasant Valley

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

d. STREET ADDRESS:

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Miss 'Fannie — Middle: V — Last: Geiman

4. DATE OF DEATH: Month: March — Day: 25 — Year: 1957

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Sept 7, 1876

9. AGE (In years last birthday): 80 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY: Canning Factory

11. BIRTHPLACE (State or foreign country): Md

12. CITIZEN OF WHAT COUNTRY?: US

13. FATHER'S NAME: Edward Geiman

14. MOTHER'S MAIDEN NAME: Alverta Bankart

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 218-10-7477

17. INFORMANT: Charles E. Geiman — Address: Pleasant Valley, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 7 days

DUE TO (b): arteriosclerosis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Mar 19, 1957 to Mar 25 1957 that I last saw the deceased alive on Mar 29, 1957, and that death occurred at 10 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE M.D. — ADDRESS (Street, city or town, state): 15 Center Ave Westminster — DATE SIGNED: 3/26/57

PHYSICIAN'S NAME (Type): Dr E. Reese Wilkens

22a. BURIAL, CREMATION, REMOVAL (Specify): burial

22b. DATE THEREOF: Mar 28, 1957

22c. NAME OF CEMETERY OR CREMATORY: St. Matthew's Cemetery

22d. LOCATION (City, town, or county) (State): Pleasant Valley, Md

23. FUNERAL DIRECTOR'S SIGNATURE: Mervyn C. Fuss — ADDRESS: Taneytown, Md.

24a. REC'D BY REGISTRAR DATE: MAR 28 1957

24b. REGISTRAR'S SIGNATURE: Harriet Miller

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02729 CERTIFICATE OF DEATH

02761
Reg. Dist. No. 76

1. PLACE OF DEATH
a. COUNTY CARROLL MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WESTMINSTER
c. LENGTH OF STAY IN 1b 30 YRS.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 70 MADISON ST.

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE MARYLAND b. COUNTY CARROLL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WESTMINSTER
d. STREET ADDRESS 70 MADISON ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First RAY Middle CLEVELAND Last GREEN

4. DATE OF DEATH Month MARCH Day 23 Year 1957

5 SEX MALE

6. COLOR OR RACE WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH Sept. 14, 1890

9. AGE (In years last birthday) 66 yrs.
IF UNDER 1 YEAR: Months | Days
IF UNDER 24 HRS.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARPENTER

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) CARROLL CO. Md.

12 CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Isaac N. GREEN, JR.

14. MOTHER'S MAIDEN NAME FANNIE FLATER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO 217-07-3457

17. INFORMANT Address MRS. RAY C. GREEN, WESTMINSTER, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary artery disease — INTERVAL BETWEEN ONSET AND DEATH 2 years

DUE TO (b) arteriosclerosis — 3 and years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Asthma for many years

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from March 5, 1955, to 3-22, 1957, that I last saw the deceased alive on 3-22, 1957, and that death occurred at 3 9 M, from the causes and on the date stated above.

ACTUAL SIGNATURE C. L. Billingslea M.D. ADDRESS (Street), city or town, state) Westminster, Md. DATE SIGNED 3-23-57

PHYSICIAN'S NAME (Type) C. L. Billingslea Westminster, Md.

22a. BURIAL, ~~CREMATION~~, REMOVAL (Specify) BURIAL

22b. DATE THEREOF 3/25/57

22c. NAME OF CEMETERY OR ~~CREMATORY~~ SANDYMOUNT CEM.

22d. LOCATION (City, town, or county) (State) FINKSBURG, RD #1, Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS J. E. Myers, Jr., Westminster, Md.

24a. REC'D BY REGISTRAR DATE 3-24-57

24b. REGISTRAR'S SIGNATURE Hamick Miller

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the ... director, page 3 should be ... for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02754 02762

CERTIFICATE OF DEATH

Reg. Dist. No. 75

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Manchester Rural
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Westminster Rd

2 USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
a. STATE: Maryland b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Manchester Rural
d. STREET ADDRESS: Westminster Rd
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Margaret Middle: Lizetta Last: Grosse
4. DATE OF DEATH: Month: March Day: 4 Year: 19 57

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: July 7, 1877
9. AGE (In years last birthday): 79 yrs
IF UNDER 1 YEAR: Months: Days:
IF UNDER 24 HRS: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Tailor
10b. KIND OF BUSINESS OR INDUSTRY: Clothing Trade
11. BIRTHPLACE (State or foreign country): Maryland
12 CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John T Grosse
14. MOTHER'S MAIDEN NAME: Barbara Weigel

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Franklin Grosse Address: Manchester Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Chronic Myocarditis — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Hypertensive Cardio Vascular disease — ?
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Hour: o. m. / p. m. Month: Day: Year: 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from March 4, 19 57 to March 4, 19 57 that I last saw the deceased alive on March 15, 19 57, and that death occurred at 12:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Joseph E Bush M.D. ADDRESS (Street, city or town, state): Hampstead Md DATE SIGNED: 3/4/57
PHYSICIAN'S NAME (Type): Joseph E. Bush MD Hampstead Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3/7/57
22c. NAME OF CEMETERY OR CREMATORY: Lutheran Cemetery
22d. LOCATION (City, town, or county): Manchester Md (State): Carroll Co

23. FUNERAL DIRECTOR'S SIGNATURE: Frederick Bucher Hammer Sr ADDRESS:
24a. REC'D BY REGISTRAR DATE: Mar. 7/57
24b. REGISTRAR'S SIGNATURE: Mrs. M.P.S. Dennee

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
ISM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02755 **CERTIFICATE OF DEATH** 02763

Reg. Dist. No. 21

1. PLACE OF DEATH a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Warfieldsburg
c. LENGTH OF STAY IN 1b: life
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: New Windsor R. 1

2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission)
a. STATE: Maryland b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Yl Warfieldsburg
d. STREET ADDRESS: New Windsor, R. 1
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First William Middle Andrew Last Haines
4. DATE OF DEATH: Month March Day 13 Year 1957

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: January 23, 1895
9. AGE (In years last birthday): 62 yrs
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer
10b. KIND OF BUSINESS OR INDUSTRY: Own Farm
11. BIRTHPLACE (State or foreign country): Carroll County, Md.
12 CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Nathan Haines
14 MOTHER'S MAIDEN NAME: Mae Carr

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): W W 1
16. SOCIAL SECURITY NO: 213-05-1664
17. INFORMANT: Mrs. Alice R. Haines R.1 New Windsor, Address Md.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Pneumonia (Hypostatic) — INTERVAL BETWEEN ONSET AND DEATH: 2 days

4 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): CardioRenal disease, arteriosclerosis — Several yrs

DUE TO (c): Paraplegia, decubitus ulcers Anemia — Several yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour o. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Feb 27, 1957, to March 13 1957, that I last saw the deceased alive on March 13, 1957, and that death occurred at 10:10 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Wylam Speicher M.D. ADDRESS (Street, city or town, state): Westminster Md DATE SIGNED: 3/14/57

PHYSICIAN'S NAME (Type): W. G. Speicher M.D. 135 E. Main St. Westminster, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3-16-57
22c. NAME OF CEMETERY OR CREMATORY: Westminster
22d. LOCATION (City, town, or county) (State): Westminster, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: John R. Byers Westminster, Md.
24a. REC'D BY REGISTRAR DATE: 3-18-57
24b. REGISTRAR'S SIGNATURE: Harriet Mullin

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4) 1SM 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 1c, 4, 21 Film C213 4-1-57 et

02753

02764

CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville,
c. LENGTH OF STAY IN 1b: 14 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Balto City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 3924 Elm Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Howard — Middle: Marshall — Last: Haynes

4. DATE OF DEATH: Month: 3 — Day: 30 — Year: 19 57

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 3-14-91

9. AGE (In years last birthday): 66 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): mechanic

10b. KIND OF BUSINESS OR INDUSTRY: AUTOMOBILE

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Marshall Haynes

14. MOTHER'S MAIDEN NAME: Deliah

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): —
(If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: unkn

17. INFORMANT — Address: Hospital Records

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Thrombosis of lenticulostriate artery — INTERVAL BETWEEN ONSET AND DEATH: hours

DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Generalized arteriosclerosis — years

DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Chron. brain syndr. assoc. with circulatory disturbance

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour: o. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 3-15- 19 57, to 3-29-30- 19 57, that I last saw the deceased alive on 3-28-29- 19 57, and that death occurred at 1:20 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Edmund B. Justhaus M.D.
ADDRESS (Street, city or town, state): Springfield State Hospital
DATE SIGNED: 3-29-57

NAME (Type): Edmund B. Justhaus — Sykesville, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 4-2-57
22c. NAME OF CEMETERY OR CREMATORY: ST MARY'S
22d LOCATION (City, town, or county) (State): HAMPDEN

23. FUNERAL DIRECTOR'S SIGNATURE: Paul E. Johnson — ADDRESS: 3615-17 Chestnut Ave

24a. REC'D BY REGISTRAR — DATE: 4/1/57
24b. REGISTRAR'S SIGNATURE: C. Harry Keers

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02757 **CERTIFICATE OF DEATH** 02765

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Taneytown
c. LENGTH OF STAY IN 1b: 20 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X2 Taneytown
d. STREET ADDRESS: /
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Harry — Middle D. G. — Last Hilterbrick

4. DATE OF DEATH: Month March — Day 4 — Year 1957

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: July 29, 1881
9. AGE (In years last birthday): 75 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Farmer
10b. KIND OF BUSINESS OR INDUSTRY: Own farm
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Henry J. Hilterbrick
14. MOTHER'S MAIDEN NAME: Arminta M. Shoemaker

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 217-18-8708
17. INFORMANT: Mrs. Helen Hilterbrick, Taneytown, Maryland — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Chronic Myocarditis — INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Arteric Sclerosis
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from March 3, 1957, to 3/4, 1957, that I last saw the deceased alive on 3/4, 1957, and that death occurred at 4 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: T. H Legg M.D. — ADDRESS (Street, city or town, state): Union Bridge Md — DATE SIGNED: 3-5-57

PHYSICIAN'S NAME (Type): T. H Legg MD — Union Bridge MD

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: March 7, 1957
22c. NAME OF CEMETERY OR CREMATORY: Lutheran Cemetery
22d. LOCATION (City, town, or county) (State): Taneytown, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Merwyn C. Fuss — Merwyn C. Fuss — ADDRESS: Taneytown, Maryland
24a. REC'D BY REGISTRAR, DATE: MAR 7 '57
24b. REGISTRAR'S SIGNATURE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02753

CERTIFICATE OF DEATH

02766

Reg. Dist. No. 74

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 24 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: C.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 2421 Mosher St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Marian — Middle: Jane — Last: Horsmon

4. DATE OF DEATH: Month: March — Day: 3 — Year: 1957

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 6-27-1887
9. AGE (In years last birthday): 69 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Calvert County, Md
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Thomas J Fowler
14. MOTHER'S MAIDEN NAME: Medora King

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: none
17. INFORMANT — Address: Mrs. Edward D. Bayly - 122 Walbrook Rd. -Balto. 29

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 2 hrs

DUE TO (b): Arteriosclerosis, Generalized — more than 10yrs

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): Arrested pulmonary Tb with hypochromic Anemia 11 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Schizophrenic Reaction, catatonic type
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Aug. 1 1933, to March 3 1957, that I last saw the deceased alive on March 3 1957, and that death occurred at 11:30 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Gertrud Sonnenfeldt M.D. — ADDRESS (Street, city or town, state): Springfield State Hospital — DATE SIGNED: 3.3.57

PHYSICIAN'S NAME (Type): Gertrud Sonnenfeldt

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3/6/57
22c. NAME OF CEMETERY OR CREMATORY: Meadowridge Mem. Pk.
22d. LOCATION (City, town, or county) (State): Howard Co., Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Wm. J. Pickener & Sons — ADDRESS: Balto. 17, Md.
24a. REC'D BY REGISTRAR DATE: 3/5/57
24b. REGISTRAR'S SIGNATURE: A. H. Hedrick

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02767

02759

CERTIFICATE OF DEATH

Reg. Dist. No. 14

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 14y 6mo 20d

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital
d. STREET ADDRESS: Paper Mill Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Bessie — Middle: — Last: Hudson

4. DATE OF DEATH: Month: March — Day: 9 — Year: 1957

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 7-4-1893
9. AGE (In years last birthday): 63 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Nelson Trumpower
14. MOTHER'S MAIDEN NAME: Lucie Sommer

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: none
17. INFORMANT: Address: Hospital records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cancer of the cervix uteri — INTERVAL BETWEEN ONSET AND DEATH: 5 y
171 X
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Psychosis with meningo-encephalitis
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year: Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July - 1 - 19 56 to March - 9 - 19 57 that I last saw the deceased alive on March - 9 - 19 57, and that death occurred at 1:45 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Walther H. Sonnenfeldt M.D.
ADDRESS (Street, city or town, state): Springfield State Hospital
DATE SIGNED: 3/15/57
PHYSICIAN'S NAME (Type): Walther H. Sonnenfeldt

22a. BURIAL, CREMATION, REMOVAL (Specify): Embalming
22b. DATE THEREOF: March 12, 1957
22c. NAME OF CEMETERY OR CREMATORY: Mt. Olivet Cemetery Board
22d. LOCATION (City, town, or county) (State): Baltimore Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Frank D. Newell
ADDRESS: Westminster Md.
24a. REC'D BY REGISTRAR DATE: 3-15-57
24b. REGISTRAR'S SIGNATURE: C. Harry Myers

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VII A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02768

02769 **CERTIFICATE OF DEATH**

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH a. COUNTY: Carroll — MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland — b. COUNTY: Dorchester
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Henryton — c. LENGTH OF STAY IN 1b: 797 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cambridge c9-1.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Henryton State Hospital	d. STREET ADDRESS: 10 Dobson Street — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
Robert	James	Jackson	3	12	19 57

5. SEX	6. COLOR OR RACE	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	Negro		7-29-1900	56 yrs		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer	Phillips Packing Co.	Cambridge, Maryland	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
James Jackson	Sadie Styles

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
No	214-07-8200	Robert James Jackson - Patient

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Insufficiency — INTERVAL BETWEEN ONSET AND DEATH: 1952

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) Far advanced bilateral pulmonary Tuberculosis with cavitation.

DUE TO

(c) Extensive pulmonary fibrosis

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a). — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from January 5, 1955, to March 12, 19 57, that I last saw the deceased alive on March 12, 19 57, and that death occurred at 1:20 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: T. F. Vestal, M.D. — ADDRESS (Street, city or town, state): Henryton, Maryland — DATE SIGNED: 3-12-57

PHYSICIAN'S NAME (Type): T. F. Vestal, Superintendant — Henryton State Hospital, Henryton, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	3-17-57	Waugh Cemetery	Cambridge, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	24a. REC'D BY REGISTRAR DATE 3-12-57	24b. REGISTRAR'S SIGNATURE
Herbert M. Sellers Jr.			Albert R. Swan Registrar

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02761

02769

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH
a. COUNTY Carroll — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Carroll

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Westminster

c. LENGTH OF STAY IN 1b: Life

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Westminster x2

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Westminster, Md. R.D.1 (Union Mills)

d STREET ADDRESS: Westminster, Md. R-1 (Union Mills)

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Elizabeth — Middle ——— — Last Kemp

4. DATE OF DEATH: March Month 10 Day Year 1957 — March 10, 1957 — 19

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8 DATE OF BIRTH: April 11, 1869

9. AGE (In years last birthday): 87 (87) yrs

IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Artist & Poet

10b. KIND OF BUSINESS OR INDUSTRY: Painting & Poetry

11. BIRTHPLACE (State or foreign country): Carroll Co., Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Henry Wirt Shriver

14. MOTHER'S MAIDEN NAME: Mary Jane Winebrenner

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT Mrs. John T Laning Address: Mrs. John T. Laning, Westminster, Md. R.D.1

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE — INTERVAL BETWEEN ONSET AND DEATH: IMMEDIATE

331X

DUE TO (b) ARTERIO SCLEROSIS — 10 YRS

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): FRACTURE RIGHT HIP

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) FELL TO FLOOR

20c. TIME OF INJURY Hour 5:00 a. m. p. m. Month, Day, Year 3-10 1957

20d. INJURY OCCURRED While at work ☐ Not while at work ☒ C

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) HOME

20f. (City or town) (County) (State) WESTMINSTER, CARROLL, Md.

21. I certify that I attended the deceased from 1-19, 1952 to 3-10, 1957, that I last saw the deceased alive on 2-26, 1957, and that death occurred at 5.00 P. M, from the causes and on the date stated above.

ACTUAL SIGNATURE L. L. Potter M.D. ADDRESS (Street, city or town, state) 12 W. King St. Littlestown, Pa DATE SIGNED 3-11-57

PHYSICIAN'S NAME (Type) L. L. POTTER M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial

22b. DATE THEREOF 3/13/57

22c. NAME OF CEMETERY OR CREMATORY St. Marys Cemetery

22d LOCATION (City, town, or county) (State) Silver Run, Carroll Co., Md.

23. FUNERAL DIRECTOR'S SIGNATURE Richard A. Little ADDRESS Littlestown, Pa.

24a. REC'D BY REGISTRAR DATE 3-12-57

24b REGISTRAR'S SIGNATURE Vernon . . .

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02770

02730

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH
a. COUNTY: CARROLL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WESTMINSTER
c. LENGTH OF STAY IN 1b: 49 YRS.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 35 N. CENTER ST.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MD. b. COUNTY: CARROLL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WESTMINSTER
d. STREET ADDRESS: 35 N CENTER
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First RUTH Middle CAPLE Last MATHIAS

4. DATE OF DEATH: Month MARCH Day 20 Year 1957

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: AUGUST 25, 1907

9. AGE (In years last birthday): 49 yrs
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS: Hours ___ Min ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): MD.

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: GEORGE H. CAPLE

14. MOTHER'S MAIDEN NAME: NORA BUCHMAN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO: —

17. INFORMANT: JOSEPH L. MATHIAS JR. Address 35 N CENTER WESTMINSTER, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma Left Breast & metast — INTERVAL BETWEEN ONSET AND DEATH: 1948
DUE TO (b): Mets to Mediastinal Glands & Pulmonary System
DUE TO (c): Anemia & Cachexia — Several yrs

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

170X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year: Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from November 15 to March 20, 1957, that I last saw the deceased alive on March 20, 1957, and that death occurred at 3:45 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: W Glenn Speicher M.D. ADDRESS (Street, city or town, state): Westminster Md DATE SIGNED: 3/22/57

PHYSICIAN'S NAME (Type): W. GLENN SPEICHER M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 3-23-1957

22c. NAME OF CEMETERY OR CREMATORY: WESTMINSTER CEMETERY

22d. LOCATION (City, town, or county) (State): WESTMINSTER MD.

23. FUNERAL DIRECTOR'S SIGNATURE: David R. Bankard ADDRESS: Westminster, Md

24a. REC'D BY REGISTRAR DATE: March 26, 1957

24b. REGISTRAR'S SIGNATURE: Hamit Grilly

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02762

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02771

Reg. Dist. No. 74

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): rural--Sykesville
c. LENGTH OF STAY IN 1b: 5 mos.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): x/ rural--Sykesville
d. STREET ADDRESS: /
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First PEARL — Middle PENELOPE — Last MAYFIELD

4. DATE OF DEATH: Month March — Day 23 — Year 1957

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: March 25,1893

9. AGE (In years last birthday): 63 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife

10b. KIND OF BUSINESS OR INDUSTRY: home

11. BIRTHPLACE (State or foreign country): Penna.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: James Brewer

14. MOTHER'S MAIDEN NAME: Lucinda M. Rudolph

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: none

17. INFORMANT: Calvin W. Mayfield, Same — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Hypertensive C-V disease — INTERVAL BETWEEN ONSET AND DEATH: Years.

443X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b):

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: James T. Marsh M.D.

EXAMINER'S NAME (Type): JAMES T. MARSH

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: 3/27/57

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 3-25-1957

22c. NAME OF CEMETERY—~~OR CREMATORY~~: Ebenezer

22d. LOCATION (City, town, or county) (State): Carroll Co., Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: C. L. Waltz, ADDRESS: Winfield, Md.

24a. RECD BY REGISTRAR DATE: APR 2 1957

24b. REGISTRAR'S SIGNATURE: C. Harry Geers

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the [illegible] Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02763 02772

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 3 y 1 m
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Balto City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 12 Valley Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Anna; Middle: Christiana; Last: Mc Geeney

4. DATE OF DEATH: Month: 3; Day: 16; Year: 19 57

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 8-8-78

9. AGE (In years last birthday): 78 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12 CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Frank Hagert

14. MOTHER'S MAIDEN NAME: Elizabeth Kirschbaum

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): unkn
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 215-03-1022

17. INFORMANT: Hospital Records
Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: weeks

331X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(b) Encephalopathy due to hemorrhage — weeks
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Chr. brain syndr. assoc. with senile brain disease with psych. react.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. / Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 10-20- 19 54 to 3-16- 19 57 that I last saw the deceased alive on 3-16- 19 57, and that death occurred at 10 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Edmund B. Leuthaus M.D.
ADDRESS (Street, city or town, state): Springfiedd State Hospital
DATE SIGNED: 3-16-57

PHYSICIAN'S NAME (Type): Edmund B. Leuthaus — Sykesville, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify)

22b. DATE THEREOF: 3-19-57

22c. NAME OF CEMETERY OR CREMATORY: Baltimore Cem.

22d. LOCATION (City, town, or county) (State): Baltimore-Maryland

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: John C. Miller Inc.-2431 E. Oliver St. Balto.-13-Md.

24a. REC'D BY REGISTRAR DATE: MAR 20 '57

24b. REGISTRAR'S SIGNATURE: C. Barry Keene

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02764 Ice

CERTIFICATE OF DEATH

Reg. Dist. No. 02773

1. PLACE OF DEATH
a. COUNTY Carroll MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Finksburg
c. LENGTH OF STAY IN 1b 62 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE Maryland b. COUNTY Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Finksburg
d. STREET ADDRESS Sandymount Rd.
IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First ORA Middle TESTIE Last MECKLEY

4. DATE OF DEATH Month March Day 21 Year 1957

5. SEX Female
6. COLOR OR RACE White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH December 19, 1893
9. AGE (In years last birthday) 63 yrs
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME George Barnhart
14. MOTHER'S MAIDEN NAME Mary Flater

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Address Mrs. Mildred Black Finksburg Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH Minutes
DUE TO (b) Arteriosclerosis - generalized
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) Diabetes Mellitus

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July, 1956 to March 21, 1957, that I last saw the deceased alive on March 11, 1957, and that death occurred at 11:15 PM, from the causes and on the date stated above.

ACTUAL SIGNATURE Clarence E. McWilliams M.D.
ADDRESS (Street, city or town, state) Westminster, Maryland
DATE SIGNED March 21, 1957
PHYSICIAN'S NAME (Type) CLARENCE E. MC WILLIAMS, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
22b. DATE THEREOF March 24/57
22c. NAME OF CEMETERY OR ~~CREMATORY~~ Sandymount Cemetery
22d. LOCATION (City, town, or county) (State) Finksburg Md RD #1

23. FUNERAL DIRECTOR'S SIGNATURE D. E. Myers, Jr.
ADDRESS Westminster, Md
24a. REC'D BY REGISTRAR DATE 3-22-57
24b. REGISTRAR'S SIGNATURE Harriet Mills

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the director, page 3 should be detached and filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be used for use as the burial-transit permit. Then please remove carbon papers.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02765 CERTIFICATE OF DEATH

Reg. Dist. No. 02774 74

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 3yrs.10mos.28days

2. USUAL RESIDENCE (Where deceased lived. If institution- Residence before admission)
a. STATE: Maryland
b. COUNTY: Balto.City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital
d. STREET ADDRESS: 1806 N. Dallas Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: William — Middle: C. — Last: MERRYMAN
4. DATE OF DEATH: Month: March — Day: 14 — Year: 1957

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: July 9, 1887
9. AGE (In years last birthday): 69 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Machinist
10b. KIND OF BUSINESS OR INDUSTRY: -
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: William F. Merryman
14. MOTHER'S MAIDEN NAME: Annie Bull

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): World War I (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: -
17. INFORMANT: Springfield Hospital Records — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Hypertensive cardiovascular disease — INTERVAL BETWEEN ONSET AND DEATH: Years
443X
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 2601 — DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Chronic Brain Syndrome with cerebral arteriosclerosis with psychotic reaction. Diabetes Mellitus.
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from March 7, 1955, to March 14, 1957, that I last saw the deceased alive on March 14, 1957, and that death occurred at 9:15A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Agustin del Campo M.D. — ADDRESS (Street, city or town, state): Springfield State Hospital — DATE SIGNED: 3/14/57
PHYSICIAN'S NAME (Type): Agustin delCampo, M.D. — Sykesville, Maryland.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Mar 16/57
22c. NAME OF CEMETERY OR CREMATORY: Lorraine Park
22d. LOCATION (City, town, or county) (State): Windsor Mill Rd. Md

23. FUNERAL DIRECTOR'S SIGNATURE: Austin E. Donovan — ADDRESS: 3818 Roland Ave.
24a. REC'D BY REGISTRAR DATE: MAR 15 1957
24b. REGISTRAR'S SIGNATURE: C. Henry Lewis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 shall be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02775

02766 **CERTIFICATE OF DEATH**

Reg. Dist. No. 74

15

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 1yr.2mo.7days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Sprin field State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Howard
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkridge
d. STREET ADDRESS: 1927 Elkridge Heights Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Charles — Middle: Anthony — Last: MEWSHAW

4. DATE OF DEATH: Month: March — Day: 7 — Year: 19 57

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 8-2-68
9. AGE (In years last birthday): 88 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Train Master
10b. KIND OF BUSINESS OR INDUSTRY: B.O.R.R.
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Joseph L. Mewshaw
14. MOTHER'S MAIDEN NAME: Anne Martin

15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no or unknown): Unk — (If yes, give war or dates of service): NO
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Address: Records - Springfield State Hospital - Sykesville

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Pronchopneumonia - Hypostatic — INTERVAL BETWEEN ONSET AND DEATH: days

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO (c): Arteriosclerotic Cardiovascular Heart Disease — Generalized Arteriosclerosis — 10 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): CBS associated with senile brain disease, with psychotic reaction.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 5-11-56, 19___, to 3-7-57, 19___, that I last saw the deceased alive on 3-6, 19 57, and that death occurred at 1:50 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Walther H. Sommerfeldt, M.D. — ADDRESS (Street, city or town, state): Springfield State Hospital — DATE SIGNED: 3-7-57

PHYSICIAN'S NAME (Type): Walther H. Sommerfeldt, M.D. — Sykesville, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 22b. DATE THEREOF: March 1957 — 22c. NAME OF CEMETERY OR CREMATORY: Mt. Cathedral — 22d. LOCATION (City, town, or county) (State): Baltimore Md

23. FUNERAL DIRECTOR'S SIGNATURE: Jno F. Seipl — ADDRESS: 5311 Edmondson Ave

24a. REC'D BY REGISTRAR DATE: 3-7-57 — 24b. REGISTRAR'S SIGNATURE: C. Harry Weis

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02776

02767 **CERTIFICATE OF DEATH**

Reg. Dist. No. 74

1 PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND

2. USUAL RESIDENCE (Where deceased lived — If institution — Residence before admission)
a. STATE: Maryland — b. COUNTY: Baltimore City 311

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville

c. LENGTH OF STAY IN 1b: 12 days

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore. 3 W 01-4

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital.

d. STREET ADDRESS: 1532 Greendale Road Balt.18

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Carmela — Middle: (Ronzetti) — Last: Muratore

4. DATE OF DEATH: Month: March — Day: 3 — Year: 1957

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 7-23-87

9. AGE (In years last birthday): 69 yrs

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Home work

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Italy

12 CITIZEN OF WHAT COUNTRY? Italy

13. FATHER'S NAME: Angelo Muratore

14. MOTHER'S MAIDEN NAME: Susanna D'Adamo

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address: Hospital records.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Hypertensive cardio vascular disease — INTERVAL BETWEEN ONSET AND DEATH: years

4423A

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Chronic brain syndrome associated with arteriosclerosis (cerebral) with psychotic reaction. Diabetis mellitus

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTE ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 2-19 1957, to 3-3- 1957, that I last saw the deceased alive on 3-3 1957, and that death occurred at 1.19p M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Agustin del Campo M.D. — ADDRESS (Street, city or town, state): Springfield State Hospital. — DATE SIGNED: 3-3-1957

PHYSICIAN'S NAME (Type): Agustin del Campo.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Mar 7 1957

22c. NAME OF CEMETERY OR CREMATORY: Holy Redeemer

22d. LOCATION (City, town, or county) (State): Baltimore

23. FUNERAL DIRECTOR'S SIGNATURE: Fred W Cazzastra — ADDRESS: 1970 Eastern Ave

24a. REC'D BY REGISTRAR DATE: 3/6/57

24b. REGISTRAR'S SIGNATURE: C. Harry Heer

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02763

02777

CERTIFICATE OF DEATH

Reg. Dist. No. 14

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 22 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
d. STREET ADDRESS: 950 Braddock Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Lillian — Middle: Undine — Last: Neff

4. DATE OF DEATH: Month: 3 — Day: 23 — Year: 1957

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 1-10-88

9. AGE (In years last birthday): 69 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): store owner

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Carl Underdonk

14. MOTHER'S MAIDEN NAME: Zella Mc Donald

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: unkn

17. INFORMANT: Hospital Records — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Pulmonary embolism — INTERVAL BETWEEN ONSET AND DEATH: hours

465 X

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 260X

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diabetes, Chr. brain syndr. assoc. with cerebral arteriosc.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 3-1- , 1957 , to 3-23 , 1957 , that I last saw the deceased alive on 3-23- , 1957 , and that death occurred at 6 PM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Edmund B. Lusthaus M.D. — ADDRESS (Street, city or town, state): Springfield State Hospital — DATE SIGNED: 3-24-57

PHYSICIAN'S NAME (Type): Edmund B. Lusthaus — Sykesville, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 3-26-57

22c. NAME OF CEMETERY OR CREMATORY: Cumberland

22d. LOCATION (City, town, or county) (State): Cumberland, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Louis Stein Inc. — ADDRESS: Cumberland, Md.

24a. REC'D BY REGISTRAR DATE: 3-25-57

24b. REGISTRAR'S SIGNATURE: A. Hilty Weer

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be delivered to the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02778

02769 **CERTIFICATE OF DEATH**

Reg. Dist. No. 7H

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: C ✓

1b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville

c. LENGTH OF STAY IN 1b:

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 11 3Y

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

d. STREET ADDRESS: 3743 Beech Avenue

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Anna — Middle: Wheeler — Last: Pace

4. DATE OF DEATH: Month: March — Day: 5 — Year: 1957

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 10-31-1870

9. AGE (In years last birthday): 86 yrs.

IF UNDER 1 YEAR: Months / Days

IF UNDER 24 HRS.: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Dressmaker Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Frederick Tom. Wheeler

14. MOTHER'S MAIDEN NAME: Susanna Simons

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO: None

17. INFORMANT: Hospital Record — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Uremia — INTERVAL BETWEEN ONSET AND DEATH: 5 days

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Arteriosclerotic Cardiovascular Disease — 3 years
DUE TO (c): And Diabetes Mellitus — 3 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Chron. brain syndrome ass. c disturb. of metabolism, growth or nutrition & senile — 19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Brain disease

20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from 6-25, 1954, to 3-5, 1957, that I last saw the deceased alive on March 5, 1957, and that death occurred at 2:15 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Gertrud Sonnenfeld M. D. M.D. — ADDRESS (Street, city or town, state): Springfield State Hospital Sykesville Md. — DATE SIGNED

PHYSICIAN'S NAME (Type): Gertrud Sonnenfeld M.D. Springfield State Hospital Sykesville Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 3-8-57

22c. NAME OF CEMETERY OR CREMATORY: Loudon Park Cemetery

22d. LOCATION (City, town, or county) (State): Baltimore, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Horace A Burgee — ADDRESS: 3131 Gallo Rd.

24a. REC'D BY REGISTRAR DATE: 3-5-57

24b. REGISTRAR'S SIGNATURE: C. Hungerford

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02770

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02779

Reg. Dist. No. 74

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the [redacted] Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to cremation, or removal.

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 2 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: Maryland — b. COUNTY: Balto. City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 3 W 01 4
d. STREET ADDRESS: 2600 Maryland Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Leroy — Middle: Dawson — Last: PIERCY

4. DATE OF DEATH: Month: March — Day: 18, — Year: 1957

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Dec. 15, 1913

9. AGE (In years last birthday): 43 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Factory worker

10b. KIND OF BUSINESS OR INDUSTRY: -

11. BIRTHPLACE (State or foreign country): North Carolina

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Robert Edgar Piercy

14. MOTHER'S MAIDEN NAME: Bessie Bridges

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): -

16. SOCIAL SECURITY NO.: 239-10-5718

17. INFORMANT — Address: Springfield Hospital Records.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Supperative bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 36 hrs. plus
491x
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c): Acute Brain Syndrome associated with alcohol intoxication.

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☒ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Patient fell to floor in seizure.

20c. TIME OF INJURY — Hour / Month, Day, Year: 8:30 P.M. 3/17/ 1957

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Hospital

20f. (City or town) (County) (State): Sykesville Carroll Maryland

21. I certify that I took charge of the remains described above, held on Autopsy ☒, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: James T. Marsh M.D.
EXAMINER'S NAME (Type): James T. Marsh, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 3/19/57

22a. BURIAL, CREMATION, REMOVAL (Specify): Interment
22b. DATE THEREOF: 3/20/57
22c. NAME OF CEMETERY OR CREMATORY: Hickory
22d. LOCATION (City, town, or county) (State): North Carolina

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Austin E. Donovan - 3818 Roland Ave

24a. REC'D BY REGISTRAR — DATE: MAR 21 1957

24b. REGISTRAR'S SIGNATURE: C. Harry Lewis

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02780

02771 **CERTIFICATE OF DEATH**

Reg. Dist. No. 74

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 26 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Balto City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 31, Md.
d. STREET ADDRESS: 1615 Fleet Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Joseph — Middle: William — Last: Ratajczak

4. DATE OF DEATH: Month: 3 — Day: 16 — Year: 1957

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 9Ø29Ø 15(9-29-15)41

9. AGE (In years last birthday): yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): mechanic

10b. KIND OF BUSINESS OR INDUSTRY: automobile

11. BIRTHPLACE (State or foreign country): Mayland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: John Ratajczak

14. MOTHER'S MAIDEN NAME: Mary Michalak

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): unkn
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 217-09-3108 (Mich)

17. INFORMANT — Address: Hospital Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchogenic Carcinoma, undifferentiated with
DUE TO: metastases to brain

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

INTERVAL BETWEEN ONSET AND DEATH: 4 months plus

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Chr. brain syndr. assoc. with new growth, with psych, reactions

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 2-18- , 1957, to 3-16- , 1957, that I last saw the deceased alive on 3-15- , 1957, and that death occurred at 2:50 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Edmund B Lusthaus M.D. — ADDRESS (Street, city or town, state): Springfield State Hospital — DATE SIGNED: 3-16-57

PHYSICIAN'S NAME (Type): Edmund B. Lusthaus M.D. — Sykesville, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: March 20 1957

22c. NAME OF CEMETERY OR CREMATORY: St. Stanislaus

22d. LOCATION (City, town, or county) (State): Baltimore Maryland

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Lilly & Zielke Inc 403 S. Wolfe St

24a. REC'D BY REGISTRAR — DATE: MAR 18 1957

24b. REGISTRAR'S SIGNATURE: C. Harry Stees

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS ATS (4)
1SM 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02781

02772 **CERTIFICATE OF DEATH**

Reg. Dist. No. 74

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the [illegible] director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH a. COUNTY: Carroll — MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY: Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville — c. LENGTH OF STAY IN 1b: 2y 11mo 23dys	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital	d. STREET ADDRESS: 112 Lincoln Avenue — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
Charles	Reid	REYNOLDS	March	19	1957

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min
Male	White		March 20, 1895	61 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Office clerk	-	Tennessee	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
S. E. Reynolds	- Bell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
Yes	Unknown	-	Springfield Hospital Records.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: days

DUE TO (b): Lung - abscess — not known

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

491X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Involutional psychotic reaction.

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from March 25, 1954, to March 19th, 1957, that I last saw the deceased alive on March 14th, 1957, and that death occurred at 11:60P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Walther H. Sonnenfeldt M.D. — ADDRESS (Street, city or town, state): Springfield State Hospital — DATE SIGNED: 3/20/57

PHYSICIAN'S NAME (Type): Walther H. Sonnenfeldt, M.D. — Sykesville, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	3-23-1957	Lynnhurst	Knoxville, Tenn.

23. FUNERAL DIRECTOR'S SIGNATURE: Robert A Mattingly Wash. D.C. — ADDRESS: 131-11th St. N.W. — 24a. REC'D BY REGISTRAR DATE: MAR 22 19 — 24b. REGISTRAR'S SIGNATURE: C. Harry Heers

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02773

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02782

Reg. Dist. No. 76

1. PLACE OF DEATH
a. COUNTY CARROLL MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural WESTMINSTER
c. LENGTH OF STAY IN 1b 65 yr
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) LIBERTY ST. EXT'D.

2. USUAL RESIDENCE (Where deceased lived. If Institution, Residence before admission)
a. STATE MD. b. COUNTY CARROLL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural WESTMINSTER R.F.D.
d. STREET ADDRESS LIBERTY ST. EXT'D.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First GEORGE Middle ADAM Last RICKELL
4. DATE OF DEATH Month MARCH Day 26 Year 1957
5. SEX M.
6. COLOR OR RACE W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH 3-10-1877
9. AGE (In years last birthday) 80 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BRICKMASON RET.
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) MD.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME ADAM RICKELL
14. MOTHER'S MAIDEN NAME MARY SNYDER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 214-16-0412
17. INFORMANT LILLIAN G. SWINDERMAN Address 153 LIBERTY ST. WESTMINSTER, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: None.
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)
430.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE James T. Marsh M.D. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type) JAMES T MARSH
DATE SIGNED 3/26/57

22a BURIAL, CREMATION, REMOVAL (Specify) BURIAL
22b. DATE THEREOF 3-29-1957
22c. NAME OF CEMETERY OR CREMATORY St. JOHNS CEMETERY
22d. LOCATION (City, town, or county) (State) WESTMINSTER, MD.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS David A. Bankard Westminster, Md.
24a. REC'D BY REGISTRAR DATE 3-28-57
24b. REGISTRAR'S SIGNATURE Harriet Miller

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the [illegible] Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02783

02774 **CERTIFICATE OF DEATH**

Reg. Dist. No. 74

1. PLACE OF DEATH
a. COUNTY Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster
c. LENGTH OF STAY IN 1b Life
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md. — b. COUNTY Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First Emil Middle Adam Last Ruck

4. DATE OF DEATH Month March Day 31 Year 1957

5. SEX M — 6. COLOR OR RACE W — 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH May 5, 1886

9. AGE (In years last birthday) 70 yrs. — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic
10b. KIND OF BUSINESS OR INDUSTRY Automobile
11. BIRTHPLACE (State or foreign country) Md.
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME Wm Paul Ruck
14. MOTHER'S MAIDEN NAME Adeline — ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service) —
16. SOCIAL SECURITY NO. 216-14-5608
17. INFORMANT Address Mrs Clara Ruck - Sykesville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) general abdominal carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH 4-mos.

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) carcinoma, site(primary) and type unknown — ?

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from 28 March, 1957, to 31 March, 1957, that I last saw the deceased alive on 31 March, 1957, and that death occurred at 3:20 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE Wm. H. Lawson M.D. — ADDRESS (Street, city or town, state) Liberty Road at Eldersburg — DATE SIGNED 3.31.57

PHYSICIAN'S NAME (Type) Wm. H. Lawson, Jr., M.D. — Sykesville P.O., Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial — 22b. DATE THEREOF 4-3-57 — 22c. NAME OF CEMETERY OR CREMATORY Springfield — 22d. LOCATION (City, town, or county) (State) Sykesville, Md.

23. FUNERAL DIRECTOR'S SIGNATURE Ralph H. Haight — ADDRESS Sykesville, Md.

24a. REC'D BY REGISTRAR DATE 4-3-57 — 24b. REGISTRAR'S SIGNATURE C. Harry Weer

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)
15M 11/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02784

02775 **CERTIFICATE OF DEATH**

Reg. Dist. No. 7H

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND
2. USUAL RESIDENCE (Where deceased lived If institution- Residence before admission) a. STATE MARYLAND b. COUNTY GARRETT
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville
c. LENGTH OF STAY IN 1b 3 Years
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SWANTON RFD
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hosp
d. STREET ADDRESS —
e IS RESIDENCE ON A FARM? YES ☐ NO ☒
3. NAME OF DECEASED (Type or print) First MAUD Middle — Last SNYDER
4. DATE OF DEATH Month March Day 31 Year 1957
5. SEX Female
6. COLOR OR RACE White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8 DATE OF BIRTH July 9 1890
9. AGE (In years last birthday) 66 yrs.
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS Hours Min.
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY Home
11. BIRTHPLACE (State or foreign country) Maryland
12 CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME William Colmer
14. MOTHER'S MAIDEN NAME Caroline HARMON
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. —
17 INFORMANT Address Records of the Springfield St. Hosp

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Chronic Mitral Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: years

DUE TO (b) Bilateral Bronchopneumonia — days

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c) —

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
Schizophrenia - Hyperthyroidism

19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from April 20, 1950, to March 31, 1957 that I last saw the deceased alive on March 31, 1957, and that death occurred at 2 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE Gertrud Sonnenfeld M.D. ADDRESS (Street, city or town, state) Springfield State Hospital Sykesville Md. DATE SIGNED

PHYSICIAN'S NAME (Type) Gertrud Sonnenfeld Springfield State Hospital Sykesville Md.

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 4-3-57
22c. NAME OF CEMETERY OR ~~CREMATORY~~ Baltimore
22d. LOCATION (City, town, or county) (State) Baltimore Md.

23. FUNERAL DIRECTOR'S SIGNATURE Bielen Funeral Home ADDRESS Oakland, Md.
24a. REC'D BY REGISTRAR DATE 4-1-57
24b. REGISTRAR'S SIGNATURE C Harry Wiser

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02776 **CERTIFICATE OF DEATH**

Reg. Dist. No. 02785 94

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 7mos.20days.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Balto.City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d STREET ADDRESS: 2305 E. Oliver Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First George — Middle Henry — Last STECK

4. DATE OF DEATH: Month March — Day 20 — Year 1957

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: June 23, 1877
9. AGE (In years last birthday): 79 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Pipe caulker
10b. KIND OF BUSINESS OR INDUSTRY: [illegible]
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: John Steck
14. MOTHER'S MAIDEN NAME: Mary -

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): -
16. SOCIAL SECURITY NO.: 718-26-1857
17. INFORMANT: Springfield Hospital records. — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Hypertensive cardiovascular disease — INTERVAL BETWEEN ONSET AND DEATH: Years

443X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Generalized arteriosclerosis — Years
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): C.B.S.associated with circ.dist.,with cerebral arteriosclerosis,with psychotic reaction.
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July 30, 1956, to March 20, 1957, that I last saw the deceased alive on March 20, 1957, and that death occurred at 2:20 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Agustin del Campo. M.D.
ADDRESS (Street, city or town, state): Springfield State Hospital
DATE SIGNED: 3/20/57

PHYSICIAN'S NAME (Type): Agustin delCampo, M.D. — Sykesville, Maryland.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: March 23 1957
22c. NAME OF CEMETERY OR CREMATORY: Balto. Cem.
22d. LOCATION (City, town, or county) (State): Catonsville, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Leo D. Cook
ADDRESS: 1701-03 N. Patterson Park Ave.
24a. REC'D BY REGISTRAR DATE: 3/22/57
24b. REGISTRAR'S SIGNATURE: C. Harry Heeps

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 shall be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

YS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02777

CERTIFICATE OF DEATH

02786

Reg. Dist. No. 74

1. PLACE OF DEATH
a. COUNTY Carroll — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE Maryland b. COUNTY Washington

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville

c. LENGTH OF STAY IN 1b: 8 mos.

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) R.D. #1, Boonsboro ✓

d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

d STREET ADDRESS

e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Jennie Middle Catherine Last Stockslager

4. DATE OF DEATH: Month 3-8-57 Day Year 19

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 1-17-76

9. AGE (In years last birthday): 81 yrs.

IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: ---------

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John H. Jones

14. MOTHER'S MAIDEN NAME: Mary E. McNamee

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: -------

17. INFORMANT: Hospital records — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

332 X

IMMEDIATE CAUSE (a): Cerebral vascular accident — INTERVAL BETWEEN ONSET AND DEATH: 5 days

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b): Generalized arteriosclerosis — Years

DUE TO

(c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Chronic brain syndrome associated with circulatory disturbance, with cerebral arteriosclerosis, with psychotic reaction

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 6-21, 19 56, to 3-8, 19 57, that I last saw the deceased alive on 3-8, 19 57, and that death occurred at 2:00 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Gertrud Sommerfeldt M.D. ADDRESS (Street, city or town, state): Springfield State Hospital Sykesville Md. DATE SIGNED: 3/8/57

PHYSICIAN'S NAME (Type): Gertrud Sommerfeldt M.D. Springfield State Hospital Sykesville Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: March 11 1957

22c. NAME OF CEMETERY OR CREMATORY: St Marks Episcopal Cemetery

22d. LOCATION (City, town, or county) (State): Leitersburg Washington Co. Md

23. FUNERAL DIRECTOR'S SIGNATURE: East Funeral Home ADDRESS: Boonsboro Md

24b. REC'D BY REGISTRAR DATE: MAR 1 2 1957

24c. REGISTRAR'S SIGNATURE: E. Larry Sherp

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02787

02778 **CERTIFICATE OF DEATH**

Reg. Dist. No. 81

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 shall be filed with the registrar prior to Burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: CARROLL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): UNION BRIDGE
c. LENGTH OF STAY IN 1b: WEEKS
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: RURAL

2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: CARROLL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): LINWOOD
d STREET ADDRESS: RURAL
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First ROBERT Middle LEE Last STONE

4. DATE OF DEATH: Month MARCH Day 3 Year 1957

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: MARCH 3-1899

9. AGE (In years last birthday): 58 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): MASON-CONST.

10b. KIND OF BUSINESS OR INDUSTRY: BRICK & STONE

11. BIRTHPLACE (State or foreign country): MARYLAND

12 CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: HARRY STONE

14. MOTHER'S MAIDEN NAME: SARAH GROFT

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service): NO

16. SOCIAL SECURITY NO.: 219-01-7330

17. INFORMANT Address: MILDRED STONE LINWOOD, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cardiac Infarction — Interval between onset and death: Sudden

DUE TO (b): Chronic Nephritis — 6 mos

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): Hypertension — Months

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June, 19 56 to 3-3-, 1957 that I last saw the deceased alive on 3-1-, 1957, and that death occurred at 6 A. M, from the causes and on the date stated above.

ACTUAL SIGNATURE: J. H Legg M.D. ADDRESS (Street, city or town, state): Union Bridge Md DATE SIGNED: 3-3-57

PHYSICIAN'S NAME (Type): T. H LEGG M.D. UNION BRIDGE MD

22a BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b DATE THEREOF: 3/6/57

22c. NAME OF CEMETERY OR CREMATORY: PIPE CREEK CEM

22d. LOCATION (City, town, or county) (State): CARROLL COUNTY MD.

23. FUNERAL DIRECTOR'S SIGNATURE: D.E. Hartzler Sons ADDRESS: Union Bridge, Md

24a. REC'D BY REGISTRAR DATE: 3-4-57

24b. REGISTRAR'S SIGNATURE

VS A1S (4) 1SM 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02788

C2731

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1 PLACE OF DEATH
a. COUNTY CARROLL — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WESTMINSTER
c. LENGTH OF STAY IN 1b 11 YRS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 159 E. MAIN

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MD. b. COUNTY CARROLL
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WESTMINSTER
d. STREET ADDRESS 159 E. MAIN
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First HAROLD Middle LLOYD Last STULTZ
4. DATE OF DEATH Month 3 Day 29 Year 1957
5. SEX M
6. COLOR OR RACE W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 10-9-1925
9. AGE (In years last birthday) 31 yrs.
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AUTO MECHANIC
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) MD.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME THOMAS D. STULTZ
14. MOTHER'S MAIDEN NAME FANNIE ALLEN HATFIELD

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES (If yes, give war or dates of service) WW II 3-13-43 to 9-5-45
16. SOCIAL SECURITY NO. 219-20-1567
17. INFORMANT ELLAMAE STULTZ Address 159 E MAIN WESTMINSTER MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH None
DUE TO
420.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 8/7 19 57 to 3/29/57 19 57 that I last saw the deceased alive on 3/27 19 57, and that death occurred at 5:35 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE G. Allen Moulton M.D. ADDRESS (Street, city or town, state) Westminster Md. DATE SIGNED 4/30/57
PHYSICIAN'S NAME (Type) G. ALLEN MOULTON, M.D. WESTMINSTER, MD.

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF APR 1-1957
22c. NAME OF CEMETERY OR CREMATORY (Name) EVERGREEN MEMORIAL
22d. LOCATION (City, town, or county) FINKSBURG (State) MD

23. FUNERAL DIRECTOR'S SIGNATURE David A Bankard ADDRESS Westminster Md.
24a. REC'D BY REGISTRAR DATE 4-1-57
24b REGISTRAR'S SIGNATURE Harriet Miller

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be filed for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

02789

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02779

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 77

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAMPSTEAD Rural
c. LENGTH OF STAY IN 1b: visiting
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Brick Store Road

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 337 S. Calhoun St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Thomas — Middle: W — Last: Summers

4. DATE OF DEATH: Month: March — Day: 16 — Year: 1957

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Oct 14, 1900

9. AGE (In years last birthday): 56 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William T. Summers

14. MOTHER'S MAIDEN NAME: Ellen O'Day

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Minnie K. Summers — Address: 337 S. Calhoun St. Baltimore Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Coronary Thrombosis	Instant
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b)	Arterio-sclerotic C-V Disease	2-3 mo.
DUE TO (c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.): Fighting field fire - running - dropped dead

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: M. C. Porterfield M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: 3/16/57

EXAMINER'S NAME (Type): M.C.PORTERFIELD

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 3-20-1957

22c. NAME OF CEMETERY OR CREMATORY: New Cathedral

22d. LOCATION (City, town, or county) (State): Balto Md

23. FUNERAL DIRECTOR'S SIGNATURE: [illegible] — ADDRESS: Pratt & Stricker St.

24a. REC'D BY REGISTRAR — DATE: MAR 18 1957

24b. REGISTRAR'S SIGNATURE: Henry Pe[illegible]

THE DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02730 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02790

Reg. Dist. No. 14

1. PLACE OF DEATH a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 11 mos, 17 dys
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 1322 Dale Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Anna Middle Mary Last TAYLOR
4. DATE OF DEATH: Month March Day 28 Year 1957

5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: July 22, 1879
9. AGE (In years last birthday): 77 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Germany
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Karl G. Geisler
14. MOTHER'S MAIDEN NAME: Amelia -

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): -
16. SOCIAL SECURITY NO.: Unknown
17. INFORMANT Address: Springfield Hospital records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Arteriosclerotic heart disease — INTERVAL BETWEEN ONSET AND DEATH: years
420.0
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Chronic brain syndrome associated with circulatory disturbance, with cerebral arteriosclerosis, with psychotic reaction. Fractures left elbow & neck of left femur
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☒ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. [Enter nature of injury in Part I or Part II of Item 18.]: Patient slipped and fell while attempting to get off toilet,
20c. TIME OF INJURY Hour: 12:30 a.m. p.m. Month, Day, Year: 2/20/57
20d. INJURY OCCURRED Whi e at work ☐ Nat while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Hospital
20f. (City or town) Sykesville (County) Carroll (State) Md.

21. I certify that I took charge of the remains described above, held on Autopsy ☒, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE James T Marsh M.D.
EXAMINER'S NAME (Type) James T. Marsh, M.D.
CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED 3/28/57

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF 3-30-57
22c. NAME OF CEMETERY OR CREMATORY: Columbia Gardens
22d. LOCATION (City, town, or county) (State): Arlington Virginia

23. FUNERAL DIRECTOR'S SIGNATURE: C. P. Joes (agent)
ADDRESS: Arlington, Va.
24a. REC'D BY REGISTRAR DATE 3-28-57
24b. REGISTRAR'S SIGNATURE: C. Harry Greer

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please complete the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 5 Film... 02781

CERTIFICATE OF DEATH

Reg. Dist. No. 02791

1. PLACE OF DEATH
a. COUNTY: CARROLL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL, WESTMINSTER
c. LENGTH OF STAY IN 1b: 5 YRS.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 29 FAIR ST.

2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission)
a. STATE: MARYLAND
b. COUNTY: CARROLL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL, WESTMINSTER
d. STREET ADDRESS: 29 FAIR ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First CHARLES Middle WILLIAM Last WICKS

4. DATE OF DEATH: Month MARCH Day 13 Year 1957

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: SEPT. 23, 1891 (1889)

9. AGE (In years last birthday): 65 yrs.

IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FARMER

10b. KIND OF BUSINESS OR INDUSTRY: RETIRED

11. BIRTHPLACE (State or foreign country): BALTIMORE

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: GEORGE F. WICKS

14. MOTHER'S MAIDEN NAME: EMMA OSTERHUS

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) — (If yes, give war or dates of service) —

16. SOCIAL SECURITY NO. —

17. INFORMANT: EDWARD F. WICKS, WESTMINSTER Md.
Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary (occlusion) 1 yr ago 51 — INTERVAL BETWEEN ONSET AND DEATH: 15 min.

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Myocarditis (chr)
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Apr 51, 19__ to Mar 13, 1957 that I last saw the deceased alive on 3-12-, 1957, and that death occurred at 5:45 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: W. C. Jennette M.D. ADDRESS (Street, city or town, state): 103 E Main Westminster Md — DATE SIGNED: 3-13-57

PHYSICIAN'S NAME (Type): W. Carl Jennette M.D. Westminster Md

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 3/16/57

22c. NAME OF CEMETERY OR CREMATORY: DEER PARK CEMETERY

22d. LOCATION (City, town, or county) (State): RURAL WESTMINSTER

23. FUNERAL DIRECTOR'S SIGNATURE: L. S. Bayne Jr. ADDRESS: Westminster Md.

24a. REC'D BY REGISTRAR DATE: 3-14-57

24b. REGISTRAR'S SIGNATURE: Harriet ... Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 shall be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02732

CERTIFICATE OF DEATH

02792

Reg. Dist. No. 74

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN: 26 — 3y, 5mo, ~~xx~~ dy

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Fort Howard 19 03x22
d. STREET ADDRESS: Chestnut Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

3. NAME OF DECEASED (Type or print): First: William — Middle: Clyde — Last: YEATMAN

4. DATE OF DEATH: Month: March — Day: 6, — Year: 19 57

5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: July 26, 1886
9. AGE (In years last birthday): 70 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY: Shipyard
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Unk. (If yes, give war or dates of service): –
16. SOCIAL SECURITY NO.: 217-01-4525
17. INFORMANT — Address: Springfield Hospital records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 3 days
DUE TO
331X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Generalized arteriosclerosis — Years
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): C.B.S. assoc. with circul. dist. with cerebral arteriosclerosis with psychotic reaction. Pulmonary tuberculosis.
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from September 8, 19 53, to March ~~xx~~ 6, 19 57 that I last saw the deceased alive on March ~~x~~ 6, 19 57, and that death occurred at M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Walther H. Sonnenfeldt M.D.
ADDRESS (Street, city or town, state): Springfield State Hospital
DATE SIGNED

PHYSICIAN'S NAME (Type): Walther H. Sonnenfeldt, M.D. — Sykesville, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3-9-57
22c. NAME OF CEMETERY OR CREMATORY: Bellair Memorial Gardens
22d. LOCATION (City, town, or county) (State): Bel Air Md

23. FUNERAL DIRECTOR'S SIGNATURE: Walter Brooks Bradley
ADDRESS: Dundalk Md
24a. REC'D BY REGISTRAR DATE: 3-7-57
24b. REGISTRAR'S SIGNATURE: C. Harry Weer

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 13, 14 Film 212 3-10-57 et

02793

02783

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: since 2-9-57
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Howard
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Ellicott City
d. STREET ADDRESS: Waterloo Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Laura; Middle: Ellen; Last: Zimmer

4. DATE OF DEATH: Month: 3; Day: 10; Year: 1957

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 12-25-70

9. AGE (In years last birthday): 86 yrs.

IF UNDER 1 YEAR: Months; Days — IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Richard N. Forsythe

14. MOTHER'S MAIDEN NAME: Bennaire Parsons

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: unkn

17. INFORMANT: Hospital Records — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): H Brochopneumonia — INTERVAL BETWEEN ONSET AND DEATH: days
491X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b):
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Chr.brain syndr. assoc.with senile brain disease with psych.reacr

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Month, Day, Year; Hour o. m. p. m.; 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 2/9/ 19 57 to 3/10/ 19 57 that I last saw the deceased alive on 3-10- 1957, and that death occurred at 11 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Edmund Lusthaus M.D. — ADDRESS (Street, city or town, state): Springfield State Hospital — DATE SIGNED: 3-10-57

PHYSICIAN'S NAME (Type): Edmund Lusthaus — Sykesville, Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 3-12-57

22c. NAME OF CEMETERY OR CREMATORY: St Mary's Hanover

22d. LOCATION (City, town, or county) (State): Baltimore, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Wm Cook Inc. — ADDRESS: 1217 St Paul St. Balto. Md

24a. REC'D BY REGISTRAR DATE: 3-10-57

24b. REGISTRAR'S SIGNATURE: C. Harry Weis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55